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ABSTRACT

Six papers consider various aspects of the education and treatment of emotionally disturbed children. B.S. Parsonson examines the rationale and efficacy of the application of learning theory principles to the modification of deviant behavior. The need for family therapy is discussed by J.E. Ritchie, who focuses upon the environmental causes and social context of emotional disturbance. The family is seen as a possible context for distorted communications maintained as a pathological homeostasis. Therapeutic qualities of group counseling are described by D.R. Mitchell in behavioral terms (reinforcement, modeling, desensitization) while the group is seen as a social microcosm with multiple relationships. L.G. Rhodes suggests that disturbed children are possible not best served by adjustment classes, in the light of efficacy studies and study of the effects of disability labels on teacher expectancies. Institutional care of socially maladjusted children is examined by B.C. Atwool, while Muriel Blackburn focuses on the diagnosis, etiology, and treatment of autism. (KW)

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THE EDUCATION AND TREATMENT

OF

EMOTIONALLY MALADJUSTED CHILDREN:

A collection of some papers presented at a symposium held at the University of Waikato, October, 1969.

Edited by D.R. Mitchell

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CONTENTS:

Introduction by the Editor 1

D.R. Mitchell, Lecturer in Education, University of Waikato.

1. The Application of Learning Theory to the Modification of Deviant Behaviour. 3
B.S. Parsonson, Lecturer in Psychology, University of Waikato.

2. The Maladjusted Child in the Home: A Web of Interactions Suggesting the Need for Family Therapy. 23
J.E. Ritchie, Professor of Psychology, University of Waikato.

3. Group Counselling with Children and Adolescents. 31
D.R. Mitchell, Lecturer in Education, University of Waikato.

4. Are Adjustment Classes for Maladjusted Children Justified? 51
L.G. Rhodes, District Psychologist, Department of Education, Hamilton.

5. The Institutional Care of Socially Maladjusted Children. 62
B.C. Atwool, Warden, University of Waikato (formerly Principal, Kohitere Training Centre).

6. The Diagnosis and Management of the Autistic Child. 72
Muriel Blackburn, Child Psychiatrist, Hamilton.

INTRODUCTION

In recent years, there has been an increasing, albeit vague, awareness of the educational and therapeutic problems posed by an unknown number of children who are amorphously categorised as "emotionally disturbed" or "emotionally maladjusted". A working party of the Education Department's Psychological Service (1965) commented that "in New Zealand there has been much talk about emotional disturbance, a little thought, and less well-designed research. It is hoped that this selection of papers which were presented to a 1969 Waikato University symposium on the education and treatment of maladjusted children will provide an incentive for more informed thought and, hopefully, some systematic research on the topic.

Mr Parsonson examines the rationale and efficacy of approaches based on the application of learning theory principles to the modification of behaviour. He describes the various procedures that emerge from attempts to extinguish maladaptive responses, to teach the individual how to avoid making certain responses, and to teach the individual to acquire new and socially more appropriate behaviour.

Professor Ritchie discusses the implications for counselling of the recognition of the need to consider the ecology of maladjustment. In particular, he examines the family as a possible context for distorted communications which are frequently maintained as a pathological homeostasis. In brief, Professor Ritchie asserts that if the context has some part in the causation, then it must have some role in the cure. "Why," he asks, "do we go on treating as

separate that which is connected"?

My own paper, in some ways, provides a link between Mr Parsonson's exposition of behaviour therapy and Professor Ritchie's emphasis upon social context. The unique therapeutic qualities possessed by group counselling are described both in behavioural terms such as reinforcement, modelling, and desensitization, while the group is seen as a social microcosm with multiple relationships.

Mr Rhodes challenges the validity of adjustment classes in the light of efficacy studies and research into the effects of disability labels on the attitudes and expectancies of teachers. He suggests that technological and methodological innovations in education may enable maladjusted children to be retained more in the main stream of education.

Mr Atwool's examination of the institutional care of socially maladjusted children endeavours to steer a course between the idealistic conception of a therapeutic community and the reality of staff limitations, isolation from society, and the punitive aspects of institutions.

Finally, Dr Blackburn's paper on the diagnosis, aetiology and treatment of autism serves to caution one against the temptation to apply the label "autistic" to those children who baffle the diagnostician.

PAPER 1 THE APPLICATION OF LEARNING THEORY TO THE MODIFICATION OF DEVIANT BEHAVIOUR

B.S. Parsonson,
Lecturer in Psychology,
University of Waikato.

INTRODUCTION:

Over the past decade there has emerged an impressive body of literature on the application of learning theory to the modification of deviant behaviour. The protagonists of this approach have attempted to restructure our understanding of the nature of deviant behaviour because they consider that the psychiatric and psychodynamic models have failed (a) to adequately account for the underlying determinants of behaviour disorders, and (b) to provide effective treatment paradigms.

The behaviour therapists believe that maladaptive behaviour results either from the learning of inappropriate responses to certain stimulus situations or from the absence of certain responses in the individual's behaviour repertoire. On the basis of the above premise they conclude that maladaptive behaviour can be eliminated in the following ways:

(a) by extinguishing the maladaptive responses;
(b) by teaching the individual to avoid making certain responses; and
(c) by teaching the individual to make new and socially more appropriate responses.

Any one or all of these approaches may be used in any one instance, the nature of the treatment programme being dependent upon the particular maladaptive behaviours being emitted by the patient.

The general principles just outlined are the basis of a large number of treatment techniques. The availability of a range of treatment procedures is advantageous because it enables the therapist to

select that most appropriate to the patient, his environment, and his behaviour. Whereas the psychoanalyst applies psychoanalysis to all of the disturbed behaviours which he attempts to treat, the behaviour therapist is able to call upon that procedure which is likely to prove most efficacious for the particular case with which he is dealing. I will move onto a consideration of some of these techniques shortly.

Behaviour therapy with children has become increasingly popular with behaviour therapists over the past five or six years. The advantages of behaviour modification with children are stated, by Gelfand and Hartmann (1968), as being its relative brevity when contrasted with dynamic child therapies, the comparative ease with which children's social environments can be controlled, and the types of behaviour problems for which children are often referred for treatment. Ullman and Krasner (1965) note that environmental manipulation is an important constituent of most behaviour modification paradigms because it enables elimination of maladaptive behaviours and reinforcement of pro-social responses to continue beyond the clinic.

Clearly, since the child spends the majority of his time either with his family or at school, one can quite easily achieve a high degree of environmental control. Furthermore, the therapist can effectively manipulate the child's social experiences by instructing a fairly small group of people, parents and teachers, who have considerable control over the child and who are responsible for his welfare and for teaching him appropriate behaviour. In addition, these very persons already possess considerable power as reinforcement - dispensing and controlling agents in the child's environment.

In enumerating the above points, Gelfand and Hartmann (1968) also note that children are commonly referred for professional assistance because they display maladaptive behaviours which have proved among the most amenable to behaviour modification techniques. Clearly defined behaviours such as bed-wetting, phobias, temper tantrums and regressive behaviours involve relatively straight-forward behaviour therapy procedures, the efficacy of which is well documented.

Ullman and Krasner (1965) consider that the very specific and detailed instructions commonly provided to parents by behaviourally oriented therapists tend to meet with their initial treatment expectations to a greater degree than the less explicit directions, such as for increased parental acceptance and demonstrativeness, issued by dynamically oriented child therapists. It has been pointed out (Gelfand and Hartmann, 1968) that a consequence of this greater explicitness is an increased likelihood of parental cooperation. It has been suggested that parental sabotage is fairly common in traditional play-therapy programmes, with therapists frequently voicing the opinion that the parents do not honestly want an improvement in their child's adjustment. Such parental attitudes have not, thus far, been reported in behaviour therapy studies.

Other general advantages of behaviour therapy should be listed, some of these are:

(a) its effects can be assessed quantitatively rather than qualitatively;

(b) it is concerned with overt behaviour, in preference to undetermined, hypothetical internal dynamics;

(c) parents, teachers, attendants or students can be quickly trained to conduct the majority of techniques under indirect supervision;

(d) it is relatively free from many of the intellectual and socio-economic restrictions of the dynamic or long-term therapies.

TREATMENT METHODS:

Let us now move on to consider some of the behaviours treated and some of the methods of treatment. This overview is not intended to be exhaustive; those interested may further their knowledge by reference to the numerous texts on the subject by Eysenck (1960), Eysenck and Rachman (1965, Franks (1964), Krasner and Ullman (1965), Ullman and Krasner (1965,1969), Wolpe (1958), etc. and by referring to those journals explicitly devoted to behaviour therapy such as Behaviour Research and Therapy and the Journal of the Experimental Analysis of Behavior.

Treatment methods fall into three broad categories:

(1) Extinction of maladaptive behaviours; (2) Generation of pro-social behaviours; and (3) Multiple treatment techniques.

(1) Extinction of Maladaptive Behaviours:

The procedures used in the extinction process are designed to reduce the probability of occurrence of certain responses to certain stimuli. A number of strategies are applied:

(a) The individual may be taught alternative responses which are incompatible with the emission of the maladaptive response, treatment examples being counter-conditioning, systematic desensitization, reciprocal inhibition, and imitative modelling. These procedures are commonly invoked for the treatment of phobias.

A typical case of 'in vivo' systematic desensitization is reported

by Eysenck and Rachman (1965). In this instance a 9 year old boy with a bee phobia of 3 years duration, and of such intensity that he was afraid to leave the house, was initially exposed to small photographs of bees, and, by successive approximations, the programme proceeded to large photographs, coloured photographs, a dead bee in a bottle at the far end of the room, a dead bee on a coat, gradually increasing manipulations of dead bees and so on. The boy's parents were also encouraged to take him on controlled visits to a natural history museum. The boy made systematic progress to the extent that after eight sessions both he and his mother reported considerable improvement. His physical reaction - he used to go white, sweaty, cold and trembling - had abated and he was able to play alone in the garden quite comfortably. A three-month follow-up showed no recurrence of the phobia.

Reciprocal inhibition involves the presentation of the fear-arousing stimuli whilst the patient is in a state of deep relaxation. He is presented with a stimulus hierarchy, from least distressing to the most intensely disturbing stimulus situation, and asked to imagine these as vividly as possible whilst relaxed - a state which is incompatible with the tension such stimuli would normally arouse. Lazarus (1960) records the case of a 9½ year old girl who suffered night terrors, severe abdominal cramps of psychosomatic origin, bed-wetting, and fear of separation from her mother. Immediately prior to the onset of symptoms a friend of the girl had drowned in a pond, her play-mate next door had died of meningitis, and she had witnessed the death of a man in a motor accident. The girl was desensitized for a hierarchy involving increasing periods of separation

from her mother over 5 treatment sessions. The child's difficulties 'dissipated' and, at a 15 month follow-up, was reported to have "maintained an eminently satisfactory level of adjustment".

These procedures, along with counter-conditioning and modelling, have been successfully applied to combat irrational fear of water (Bentler, 1962), fear of hospitals and ambulances (Lazarus and Rachman, 1957), school phobia (Garvey and Hegrenes, 1966; Lazarus and Abramovitz, 1962; Patterson, 1965a) and dog phobias (Bandura, Grusec and Menlove, 1967; Lazarus, 1960; Lazarus and Abramovitz, 1962).

(b) Another process involves the teaching of avoidance responses to certain stimulus situations by the application of aversive shock, mild corporal punishment, or verbal remonstration.

Lazarus (1960) reported the case of a 10 year old boy who woke up between one and two a.m. every night and climbed into his mother's bed. Bribes, threats, rewards in the morning, and one night of attempted extinction - he cried for four hours before his exhausted parents gave in - all failed. Formal therapy lasted for one session. After finding that the boy genuinely wished the behaviour to cease, an electric shock apparatus was put on his arm and when he had obtained a clear image of his mother's bed he signalled and the shock was initiated. When the shock became unbearable (after an average duration of 3-5 seconds) he said aloud "my bed", and the shock was terminated. The boy received 14 trials over a 10 minute period. Mother's bed became associated with pain and his own bed with the cessation of an aversive stimulus. During the next week the boy slept in his own bed every night, waking for the first five nights

but going straight back to sleep again. The attitude of the parents to the siblings was considerably altered, becoming more favourable as a result of his changed behaviour.

The teaching of avoidance responses has also been applied to self-destructive behaviours such as head banging and punching (Mogel and Schiff, 1967; Tate and Baroff, 1966; Lovaas, Schaeffer, and Simmons, 1965) displayed by psychotic and mentally retarded children.

(c) The process of extinction, involving the non-reinforcement of the undesirable behaviour has been used extensively as a means of reducing the output of maladaptive responses. The following case was presented by Williams (1959), and serves to illustrate the use of extinction procedures.

A 21-month old boy had been seriously ill for much of the first 18 months of life. Over the latter three months his health had improved greatly. The boy ensured the continuation of the special care and attention given him during his sickness by engaging in tantrum outbursts, especially at bedtimes. If the adult left the bedroom, the child would scream and fuss until the adult returned, and a parent was spending from half an hour to two hours each bedtime waiting for the child to go to sleep. In this circumstance it was decided to withdraw reinforcement; after a leisurely and relaxed bed-time preparation the adult left the room and did not return. The length of successive tantrums reduced from 45 minutes to zero in seven sessions and this extinction remained stable over the three remaining occasions. The child smiled and made happy sounds until he fell asleep. The undesirable behaviour was reinstituted by a visiting aunt

about a week after extinction had been obtained; the child had made a fuss and the aunt returned to his room, thus reinforcing the behaviour. A second extinction series of 10 trials again removed the behaviour, which - at a 2 year follow-up had not reappeared. Extinction procedures are commonly applied to temper tantrums, anti-social behaviour, and regressive behaviours.

(2) The Generation of Pro-social Behaviours.

It is not infrequently that the therapist finds himself in the situation in which he is not so much conerned with the extinction of maladaptive behaviours as with the generation and increase of desirable behaviours. In these instances the behaviour of the child may be retarded by the absence of certain culturally or developmentally desirable behaviours. Furthermore, one often finds that where there are maladaptive behaviours, one does not only want to eliminate these but at the same time there is a need to reinforce new and more appropriate responses to the original stimuli. There exist a number of approaches to such problems but the basic essential is some form of reinforcement. Those reinforcers most commonly used with children are food, attention from adults, toys, and tokens which enable the purchase of desirable items. A combination of reinforcement procedures was used by Patterson (1955b) to modify the hyperactive behaviour of a 9 year old boy, Earl, who was severely academically retarded. He was described as being in almost continuous motion in the classroom and impossible to control unless in the immediate physical presence of the teacher. He was easily distracted, would work on lessons for only very brief periods, if at all, and would leave his desk and

wander about the room. He was stated to be particularly destructive to classmates who, although he relieved their boredom, conscientiously avoided his company. Therapy began with a base-line observation period during which Earl's behaviour was closely observed and recorded. Most of his hyperactivity was recorded as talking, pushing, hitting, pinching, gazing about the room, moving out of his desk, tapping, handling objects, squirming, etc. Following the baseline period, treatment was initiated. It involved Earl's class mates who were told that he had trouble learning things and one reason for this was that he moved around and didn't pay attention. Everytime a light, which was placed on Earl's desk, flashed, Earl would earn a penny or a piece of candy. This occurred for every 10 second period during which Earl had been attentive. A score was kept by a counter attached to a light. At the end of a period the pennies and candies which Earl had earned would be divided amongst all of the class. Briefly, the programme was such that Earl received immediate feedback reinforcement for himself (a flash of light and the turn of the counter) plus support or even social pressure from his peers.

That is, Earl's good behaviour became meaningful to both himself and also those around him, who no longer reinforced him with laughter or social approval for his disruptive behaviour - on the contrary, they reinforced his good behaviour. A four month follow-up indicated sustained improvement, both social and academic. The use of behaviour therapy in the classroom has been reported by a number of authors (Becker, et al., in press; Brown and Elliot, 1965; James, 1963; Homme, et al., 1963; O'Leary and Becker, 1967; Quay, et al., 1967; Zimmerman and Zimmerman, 1962). Behaviours treated have ranged from

hyperactivity, through aggressive behaviours to remedial reading and spelling.

Other circumstances in which reinforcement has been employed to generate new, socially approved behaviours are in the treatment of enuresis (bed-wetting) (Lovibond, 1963, 1964), toilet training (Masden, 1965; Pumroy and Pumroy, 1965; Van Wagenen and Murdock, 1966) and improvement of motor skills. In this last instance, a study by Johnston, Kelley, Harris and Wolf (1966) recorded the enhanced development of motor skills of an awkward and inhibited nursery school boy by making his teacher's attention and approval contingent upon his using a play-yard climbing frame.

(3) Multiple Treatment Techniques.

It is commonly observed that children displaying maladaptive behaviours also tend to have learned relatively few socially acceptable means of obtaining the reinforcement which their deviant responses were intended to secure. It is essential that behaviour therapists should, wherever necessary, take steps to include, in their therapy programmes, alternative means through which the client can obtain reinforcement. This approach often involves the training of parents and teachers so that they can learn which behaviours should be reinforced and which should be extinguished - as well as how to reinforce and extinguish target behaviours.

Most of the multiple treatment techniques involve the extinction of undesirable behaviours and a concomitant reinforcement programme for extending pro-social responses.

It is possible to illustrate the use of a mixed treatment

programme by reference to the case of Dicky, reported by Wolf, Risley and Mees (1964), which has become something of a classic in behaviour therapy literature. Dicky was a $3\frac{1}{2}$ year old boy who had developed cataracts in the lenses of both eyes at the age of nine months. Simultaneously, severe temper tantrums and sleep problems also appeared. A series of eye operations was conducted during Dicky's second year and it became necessary for him to wear glasses, but for more than a year his parents were unable to get him to do so.

At the time of the first referral, Dicky had been variously diagnosed as retarded, brain damaged, psychotic, and as suffering from hyperthyroidism and phenylketonuria. It was predicted that Dicky would become blind in six months if he continued to refuse to wear his glasses. In addition to his other problems, Dicky was not eating normally, displayed outbursts of temper which included self-destructive acts such as head banging, face slapping, face scratching, and hair pulling. He refused to sleep unless one of his parents remained at his bedside.

The tantrums were dealt with by a process of extinction involving time-out from reinforcement, during which Dicky was placed in a room until he had been quiet and calm for a minimum time. As time progressed, other tantrum behaviours resulted in Dicky being given time-out in isolation. Bed-time problems were similarly handled so that they did not result in reinforcing attentions. Because words like "no" and "stop that" had been backed up with aversive consequences (isolation) such words were adequate to change Dicky's eating behaviour. The new responses to bed-time and tantrum behaviours were maintained in the

home by teaching Dicky's parents to model the therapists on the ward and at home.

The problem of getting Dicky to wear his glasses continuously was approached through a shaping procedure. Dicky was reinforced with candy for successive approximations to the target behaviour. Initial progress was slow so Dicky was deprived of his breakfast and then of his lunch. The deprivations increased his interest in the reinforcer and his cooperation. At the end of 30 minutes of shaping under the condition of a strong reinforcer Dicky was placing his glasses properly and looking at objects. Subsequent progress was rapid. After glasses-wearing had been established by the use of food, weaker reinforcers such as the attendant's saying "Put on your glasses and let's go for a walk" were adequate. If Dicky removed his glasses during pleasurable occasions such as meals, walks, outdoor play etc., the activity was terminated. The investigators also used reinforcement as a means of generating new behaviours, for example bites of food served as rewards for Dicky's imitation of an attendant's labelling of pictures. After Dicky imitated, the pictures were presented without prompting. Food was required to initiate the procedure, but later adult attention and praise (social reinforcement) were effective in maintaining and expanding Dicky's appropriate use of speech. By the end of the first programme, when Dicky was five, he initiated requests and used personal pronouns correctly. He was reported as continuing to wear his glasses, displaying neither tantrums nor sleeping problems and increasing his verbal skills.

Further work was carried out on Dicky (Wolf, et al., 1967) in a

nursery school setting. Amongst the problems dealt with here were toilet training and social interactions. At the time of this latter report Dicky was able to attend public school.

In the above case we observe the application of extinction to reduce the rate of emission of undesirable behaviours such as tantrums and sleeping problems. Avoidance learning, brought about by generalization from the time-out from reinforcement encounters was then applied to the eating problem. Reinforcement using food and social reinforcers (e.g. adult attention and approval) was then applied to increase the output of socially desirable behaviours such as the wearing of glasses, picture labelling and so on.

Multiple treatment procedures are frequently employed in the treatment of delinquency, childhood psychoses, and infantile autism (see Burchard and Tyler, 1965; Ferster and De Meyer, 1961; Hingten, Sanders, and De Meyer, 1965; Leff, 1968).

METHODOLOGICAL CONSIDERATIONS:

Some of the very real problems which face those attempting to assess the efficacy and outcome of traditional psychotherapeutic or play-therapy interventions are absent in the case of behaviour therapy. Because behaviour therapists concentrate on overt, observable behaviour they are able to quantify changes in behaviour. Because they are concerned largely with operant responses to environmental contingencies they concentrate upon manipulating the environment in order to measure the effects of such manipulations upon the observed behaviour. By means of these manipulations they can further identify the dependent variables and increase the probability of effective behaviour change.

Maladaptive behaviour is not seen as a product of distorted personality dynamics, nor is the patient considered the sole repository of neurotic, psychotic, or anti-social impulses. The generation and maintenance of maladaptive behaviour is regarded as a socio-psychological phenomenon; it is a two-way operation. The behaviours of the parents, teachers, or peers serve as stimuli, models, or reinforcers for the behaviour of children. The behaviour emitted by the children generates certain responses in the parents, teachers, or peers. Within his treatment programme the behaviour therapist has to consider the socio-psychological nexus and frequently treatment programmes are directed as much at modifying the behaviour of the parents or teachers as toward modifying the behaviour of the child. Parents and teachers often do much to maintain the behaviour they wish to eliminate by overtly reinforcing such behaviour with their attention, whilst simultaneously ignoring, and thus extinguishing, the very behaviour they seek to inculcate or develop.

None of the traditional child therapies have involved parents, teachers, or attendants in the process of therapeutic intervention as deeply as have the behaviour therapies. As the many case reports will attest, giving these adults the opportunity to modify their own behaviour as part of the therapeutic programme tends to increase the chances of a more permanent behaviour change.

In order to assess, and possibly ensure, the efficacy of the treatment programme certain steps should be taken. In the first instance one has to identify the problem behaviour, this requires the therapist to ascertain the precise nature of the behaviour - what it is,

when and how frequently it occurs, what initiates it and what are its consequences. (Remember, also, that some behaviour disorders involve the absence of certain behaviours; in these instances one must note what is lacking and discover the means of evoking and increasing the frequency of appropriate behaviours.) There are two major steps in gaining relevant information: firstly, an interview with relevant adults and the child and, secondly, a follow up observation period which may involve a visit to the home or classroom. During this observation period precise data as to the nature, frequency and consequences of the behaviour should be ascertained, preferably with a quantitative record over about a week, to establish a pre-treatment or base-line estimate. By recording the data in terms of observed responses, the therapist is able to quantify and identify responses in operational terms. On the basis of this data he can draw up his therapeutic programme and identify dependent and independent variables, the particular environmental and reinforcing contingencies which he wants to manipulate. Throughout the course of therapy the rate of emission of the maladaptive responses, new adaptive responses, or both, is recorded, enabling the monitoring of progress and the institution of new procedures, where necessary, to facilitate the required changes.

In order to ascertain whether or not the changes in behaviour are being brought about by the therapeutic intervention, the reinforcing contingencies may be reversed after initial extinction or evocation criteria have been met. If the original behaviour reappears and approximates the base-rate level, one can be fairly certain that the therapeutic intervention induced the behaviour change. The therapeutic

programme is reintroduced and extinction or evocation is again achieved. In this process the therapist has used the patient as his own control, the procedure being identified as the "single organism, within-subject design"(Dinsmoor, 1966). Such an approach eliminates the necessity and problems of matched controls without detracting from the scientific validity of the experiment.

(All of the above procedures are well illustrated in a study by Allen, Hart, Buell, Harris, and Wolf (1964) in Ullman, L.P. and Krasner, L. (eds.), Case Studies in Behavior Modification, Holt, Rinehart and Winston, pp. 307-312).

Once changes in behaviour have reached the point at which therapeutic intervention can be withdrawn (i.e. symptoms are no longer manifested or target behaviours have been established in accordance with some criterion), then careful, periodic, follow-up observations should be maintained over a period of time, perhaps for some years. The follow-up should involve further behavioural observation, rather than the all-too-common phone call to parents (Gelfand and Hartmann, 1968), and should enable the therapist to obtain data regarding the re-emergence of symptoms, generalization effects, and the general progress of the patient.

The above statements may read like an experiment and this is basically what is involved in behaviour therapy - an experimental approach to the modification of behaviour. Each patient requires an individual assessment and an individual plan of treatment. Because the behaviour, the reinforcing contingencies, and the socio-environmental context differs between individuals, the behaviour therapist

has to draw upon his ingenuity and resourcefulness in order to attain his treatment goals.

There is no need to adhere rigidly to one treatment procedure or any one learning model; in fact such adherence is likely to prove disadvantageous. What is required is the application of the empirical procedures of experimental psychology within the general framework of social and clinical psychology.

To sum up, behaviour therapy is applicable to a wide variety of behaviour problems regardless of a client's intellectual capacity or socio-economic status. It seeks to manipulate reinforcement and environmental contingencies in such a way that maladaptive behaviours are extinguished and new, socially more appropriate behaviours are increasingly emitted. In fulfilling this function it draws upon the findings and methods of experimental psychology.

Behaviour therapy is more brief, thus more economical, than traditional child therapies. It is able to be assessed quantitatively, parents, teachers, attendants, and students can be taught to administer it under indirect supervision, and, finally, it has a wide range of techniques available which can be applied singly or in combination, as the individual case requires.

Note: The case studies cited in this paper were abstracted from Ullman, L.P. and Krasner, L. (1969).

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PAPER 2 THE MALADJUSTED CHILD IN THE HOME: A WEB OF INTERACTIONS SUGGESTING THE NEED FOR FAMILY THERAPY

J.E. Ritchie,
Professor of Psychology,
University of Waikato.

Since Freud tore aside the veil that hid the "reality" of family experience from public gaze and scientific inquiry we have made some progress towards an understanding of what goes on in what a recent title calls The Psycho-Social Interior of the Family.[1] The literature of clinical psychology, advanced (if that is the word) for the most part by later generations of psychoanalytic authors, has provided more detailed information, hypothesis formulation, conjecture and myth-making about the psycho-sexual interior of the family but not, I venture to assert, contributed greatly to the reduction of maladjustment we see around us: This in spite of the plethora of popular writings through which parents were, it was supposed, to be so informed of the delicacy of their task that they would succeed "better" at it. The kind of parent manuals produced by Margaret Ribble and Dorothy Baruch probably have made, and maybe continue to make, a profound contribution to parental anxiety. More recent of the same ilk, Ginott's Between Parent and Child,[2] for example, continue the tradition, interspersing between parent and child a screen of conjectural artifice, the consequences of which are quite unknown. This genre has become less specious over the years but one may still ask how far it has really affected any changes for better or for worse. There are books that shook the world but none, may I suggest, were written by Baruch. This literature needs careful sifting to assess its contribution towards the understanding of the production of maladjustment and the problem of its reduction or

treatment in the home setting.

The descriptive studies of childrearing, for example the classic of Sears and his team,[3] because they are concerned with non-clinical samples provide an interesting contrast particularly if taken along with the now extensive literature on the variation in family patterns and in child-rearing within cultures and between cultures. These studies, along with the ecological approach exemplified in the work of Barker and Wright, show us more of the setting within which maladjustment occurs and of the complexities surrounding it.

In a similar way one can travel behind and beyond the sort of acturial sign counting of the Gluecks' studies of delinquency indicators and similar work (Stott's Bristol Guides for example), to see the whole territory of interaction that lies behind the maladjusted child, the "victim" of the sick ecology within and around the family.

I had thought of speaking about our book on child-rearing in New Zealand, shortly to be published, but decided against it. In the light of its descriptive account nothing very special emerges about maladjustment in New Zealand families. The obsessions of mothers about sex, nakedness, aggression, about care of the home and property, their guilt about punishment (which doesn't prevent their use of it), the dreariness of their lives in all too many cases, the isolation and aloneness of their heavy child-bearing years, the "fun-father" present in most families (and physically absent much of the time in many), all these are things we could have assumed had their contribution to maladjustment. There are hints of more special things like the sharply inclined gradient of

achievement expectations which coincides in our society with puberty - a time complicated enough without that. But these should be discussed on a case. basis; they gain little clinical significance from survey research.

Since the early 1950's a fresh wave of integration between these stands has appeared from the development of family therapy. The initial experimental phase at Chestnut Lodge and in Bateson's group in the Veterans' Administration Hospital at Palo Alto had the usual signs of a new approach - a certain cultishness, a rapid and proselytising growth, a "special" quality, and a disregard for such practicalities as expense and administrative feasibility as a widespread technique. But over the years these qualities of a "social movement" rather than a viable treatment regimen or alternative have been burned off in fires of both practical expediency and of rational criticism and we have come to the sort of acceptance indicated by those who say "But a good therapist has always known that" or "Well if that's family therapy I've been doing it for years without knowing it!" Of course this is so. Therapy as an art uses the knowledge we know and the knowledge of which we are unaware. Even the behaviour therapist prepares his map with his mind but flies by the seat of his pants for some of the time and never more so than when his patient is moving through the crisis of real change that you only recognise after it has passed. Without family therapy, treatment is like Sisyphus and his boulder rolling. This is more true for the maladjustments of childhood even than for adult therapy where, if we accept the emphasis Jung and the third force psychologists place on the salience of health over ill health and the simple correction of growth when the person is released from limitations, there is more chance of escape from the

inevitability of relapse. In childhood the context carries the messages that spell sickness, pain and disturbance for the child. You can't cook a sweet dumpling in a sour sauce.

This emphasis on context is coming to the fore in a great many places in contemporary psychology. It is heavily dominant in the area of perceptual research. Bateson is fascinated by the power of context on communications. McLuhan has popularised the idea. Watzlawick and the group with whom he has been working, as reported in their recent Pragmatics of Human Communication,[4] hammer in the point throughout their book. Maladjustment in one person comes from a context of distorted communications and, in terms of that context, the behaviour has functional adaptive significance. A sick child is not that way from perversity, nor ontogeny, but because being sick adapts his behaviour to demands that he be sick and is reinforced by the context in which he is sick. No one inside the bubble of the family system can see this any more than a Dani in the West Irian Highlands can explain why little girls have finger joints lopped off when a relative dies or any other ritually validated, customary practice.

No one has made more complex but curiously convincing explorations of this than R.D. Laing who sees each family member as a range for other family members to "map on" their own expectations, fears, compulsions or other irrational products.[5] It's more complicated still if you "map on" to that process of Eric Berne's[6] contribution that a person may be speaking as a parent one minute and as a child the next; or speaking as a parent but expressing a child wish or need. When the characters, plot and transmission lines of the family are simple, clear, definite, well

articulated and articulate these processes, though present, may lead to bits of Goffman's public performance and everyone can enjoy the show. But introduce one act of double level communication, a disparagement disguised as a moral injunction, a snarl claimed as justified and the reactions of non-authentic role playing begin to sweep through the family communication system like static discharges between electrodes.

In the family context, the good clinician has always had a nose for the taint of distortions: the equation of fussy compulsive care with love and concern, the mother who, to keep children well, spreads hypochondria, the mystifier or moral heads-you-lose-tails-I-win bargainer who reduces the other to impotence, rage or muteness, the quiet invoker; everyone has their own list but the catalogue in clinical experience is a common one. Each is a homeostatic modality for the particular family concerned, a complex system of sub-systems located not in persons but between persons. Jackson[7] puts this in communication terms when he says that the family is a balanced system and all members act to maintain that balance either overtly or covertly. The balance is revealed by the rituals of family living and the more precarious the balance, the more effort is expended in maintaining its repetitious, circular and private systems of ritualised communication.

The stubborn-ness of maladjustment is thus explained. Who needs it? Everyone in the system needs it. Perhaps even the teacher in some cases. So, too, is the fact of so-called spontaneous recovery which Jackson thinks is <u>always</u> associated with escape from capture within the orbits of the family constellation, an escape that can be physical, topological or geographic or symbolic, social and interpersonal.

The how of all this is becoming clear. Virginia Satir's Conjoint Family Therapy[8] is a handbook of sweet clarity and sense, packed with working suggestions. Re-education techniques, especially T-group and Laboratory Training Method, have proved too valuable to be dismissed, as they are by some, as superficial phenomena of a Californian cult.

I would want to see T-group technique[9] in the classroom where the teacher has the training and the maturity to operate it and certainly in the schools where professional counsellors are at work. I would want to see Child Health Clinics and health services generally working in with the Psychological Service and with school counsellors in building up a pattern of interventions of these kinds.

We know that changes in context powerfully influence behaviour for the worse. We have always known that. The work on therapeutic communities, on folk psychiatries, and on family therapy shows how powerfully context can also influence behaviour in the direction of health, integration, growth and sanity. We also know that changes in families as in persons will not occur in a desired direction unless intervention is made and some change in readiness created. Why do we go on treating as separate that which is connected? Why do we go on denying to ourselves the satisfaction of being effective in our professional roles? Why? Because we are caught in our own contexts, me in mine, you in yours, and cannot destroy the rituals which, though they do not prevent us talking to one another, prevent us communicating in shared clinical experience. To get trapped like that is very neurotic indeed.

We need time to settle these ideas into perspective. The tradition does not go back far. Harry Stack Sullivan's only book is barely twenty years behind us and G.H. Mead's Mind Self and Society but thirty years old. The term "social psychiatry" has had little more than a decade of currency within which to act as clarion summoning ideas and research into a collective organisation. Indeed the bugle has called in troops from a number of other fronts where the fighting has grown boring and entrenched. Right now the whole of social psychology as a general field has immediate and precise relationship to this approach to the understanding of maladjustment. We inherit an embarrassment of riches.

But to be rich is not enough if we are unable to utilise the insights of these approaches and to do so requires extensions of team-work and more ancillary personnel than we have. Psychiatrists must work, often without psychologists or social workers; counsellors and others who give professional guidance must work without ready access to psychiatric aid. Most who treat see no reason why a family member who has no symptoms should take up valuable counselling time. But if he or she is part of the context then that person has some part in the causation of the sick behaviour and some role in the cure. Marriage counsellors recognise that both parties must be seen and treated but the role of the children is usually overlooked. Therapy stands for reality and must therefore work within the real gestalt.

Working in the context of the family alone is too limited a goal. Ideally the treatment should include participation in other groups, perhaps for several family members in different settings, the parents in groups with other parents, children in group sessions with other children.

Some time in the future we will have, if not enough personnel, at least more. It is a day for which we should be preparing because by so doing we increase the probability of its arrival and hasten it in time.

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PAPER 3 GROUP COUNSELLING WITH CHILDREN AND ADOLESCENTS

D.R. Mitchell,
Lecturer in Education,
University of Waikato.

I. BACKGROUND COMMENTS

Group counselling, defined by Anderson (1969, p.209) as being "professional attempts to assist non-psychotic clients to examine and modify their values or behaviour through small group interaction," is increasingly being used as a treatment of choice for maladjusted children. Indeed, such has been its popularity in recent years that one writer was constrained to apply the term "epidemic" to it (Bennett, 1963).

New Zealand has by no means remained immune to this growing interest in the therapeutic potential of group procedures, at least for adults. Among children, however, so far in this country there appears to have been only sporadic and exploratory attempts to introduce group therapy. Certainly there has been a sparsity of reports of any research on group therapy carried out in New Zealand.

An Anecdotal Diversion

My own interest in group counselling began early in 1966 when, along with a group of professional men with medical and theological backgrounds whose work gave them a common interest in the psychology of interpersonal relationships, we formed ourselves into an informal discussion group. Gradually, and spontaneously, our focus of attention moved towards an awareness of how the dynamics of our own group were acting to facilitate or impede the purposes for which we thought we

were meeting, namely the application of psychology to our respective fields. The resolution of various conflicts within this group led us, in turn, to a greater appreciation of the influence of the group on behaviour and its potential for bringing about modification in maladaptive behaviour.

Among the early learnings to take place in our group was the awareness that understanding group processes requires an emotional as well as an intellectual investment. I think I speak for the other group members when I agree with Altucher (1967) that the emotional learnings that took place in our group often produced changes that were accompanied by discomforts. To many of us, however, the shifts in emphasis from academic to personal, from distant to close, from safety to risk, from self "masking" to self-revealing culminated in relationships that we had rarely experienced. In short, we spontaneously, albeit rather painfully, evolved into a quasi-therapy group with a cohesiveness that made it one of the significant experiences of my life. Could this experience have been achieved in anything other than a group context? I think not.

Another important learning that emerged from this experience was a conviction of the importance of self-knowledge if one is to operate effectively as a group therapist. As Rogers (1960, p.17) expressed it, "I find I am more effective when I can listen acceptantly to myself and be myself." Self knowledge means, too, that the therapist can view his post-group experiencing of himself as informational data about the client. Thus, by admitting that he felt his sense of identity being threatened during the session, the therapist is better able to analyse the forces present in a group which may have led to this feeling of

threat, than the therapist who denies or fails to recognise such vicissitudes (Searles, 1965). Only by being so thoroughly aware of such counter-transference,* according to Roberts (1965, p.5) "can there be any hope of the avoidance of therapy which is adapted to the needs of the therapist rather than the needs of the patient". Those who would involve themselves in group counselling, whether as client or therapist, would do well to recognise that their psychological defenses will be exposed. Bach (1954) goes so far as to say that, in a sense, the therapist is a patient in his own group and that if the process of conducting psychotherapy fails to have a maturing effect on him, then his efforts are bound to be worthless to his patients.

A third learning was the awareness of the value of team functioning at all levels of the insight-oriented, group-oriented therapy process that we adopted. With the recognition of the benefits to be accrued from mutual supervision of techniques during our early experiences in group therapy, we decided to institute a system of dual, or co-therapists when eventually we set up therapy groups. This pattern was maintained even after initial teething pains were overcome. It seemed to offer many advantages, chief of which were the provision of a more balanced range of counselling skills, perceptual frameworks, styles of verbalization, value systems, reinforcement-givers, and transference figures. Along with these advantages, however, were the problems of reconciling

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* Transference: The process whereby a counsellee shifts emotional reactions applicable to another person onto the counsellor, e.g. directing hatred he feels towards his father onto the counsellor.

Counter transference: the process whereby the counsellor displaces repressed feelings onto the counsellee, often, but not always, as a result of the counsellee's transference.

conflicts arising from the relationships between the two therapists. To this end, brief excursions into using such devices as signals and having one therapist act as a passive observer were employed until a satisfactory working partnership emerged as a result of frank appraisal of each other's strengths and weaknesses.

Status of the Field

Despite its wide and increasingly popular application, there are few precisely determined guidelines for work in group counselling. Indeed, according to a recent statement by Anderson (1969, p.209) "despite the masses of data being collected and analysed most studies are relatively unrelated, small-scale efforts which provide only the accumulation of bits of evidence". Similar criticisms were voiced by Goldstein et al (1966, p.319) when they asserted that, with only few exceptions, the structure of contemporary group therapy practice "rests on a body of professional literature consisting overwhelmingly of anecdotal, case history, and related impressionists reports". My preceding anecdotal comments can be said, then, to have the virtue of being fashionable!

Other points raised in critical reviews of the status of the field of group counselling include reference to the lack of long term treatment studies or replication studies (Anderson, 1969), the primitive nature of much of the research methodology, and a seeming lack of awareness of each other's existence on the part of practitioners of group therapy and group dynamics researchers (Matarazzo, 1965). Further, as Mayer, et al (1969) point out, evidence regarding counsellors' relative effectiveness when employing various group procedures is almost non-existent.

In the light of the modest claim of group counselling to empirical or theoretical respectability at this point of its development, it is perhaps not surprising to read of Matarazzo's (1965, p.214) assertion that "it is still primarily a self taught art with few, if any, established or near-established principles to guide it".

II. PUBLIC COUNSELLING OR UNIQUE PROCESS?

Despite the unpromising nature of the statements in the previous section, I will aim in this section of the paper to bring together some of the more persuasive of the conjectural literature and some of the recent empirical evidence that bears upon group counselling with children.

In particular, it is my intention to examine the hypothesis that group counselling has merit, not only because of its economy of professional personnel, but also - and more importantly - because of its uniqueness as a means of facilitating changes in values or behaviour.

The Uniqueness of Group Counselling

Although some writers perceive the chief advantages of group therapy as being the maximization of the time and effort of grossly overtaxed psychological personnel, others would agree that it utilizes a segment of the psychodynamic and therapeutic spectrum which is not so readily encompassed by individual treatment. Foulkes and Anthony (1965, p.27), for example assert that it only brings the problems back to where they belong: "The community is represented in the treatment room".

In considering the wide spectrum of behaviours which are classifiable as group therapy, it is convenient to discuss the dichotomy represented by those who are individual-oriented and those who are group oriented. Expressed in another way, the range extends from those who conceive of group therapy as the public counselling of individuals to those who assert that it utilizes the unique processes present in the sociological unit of the group. At this juncture, however, I must emphasize that the dichotomy represents the extreme ends of a continuum and that, in reality, most group therapists manage to survive by a process of eclectic adaptation to the needs of the group. Most therapists operating in a group context do, in fact, attend to both individual characteristics and group dynamics.

The individual-oriented group therapist. This therapist carries over to the group setting the techniques and theory of individual psychotherapy. He leans towards psychotherapy of people in groups, whereas his group-oriented counterpart sees himself as conducting psychotherapy through groups. The extreme of this individual orientation is expressed in statements such as this one by Locke (1961, p.23):

> It must be emphasized that the individual is being treated, not the group. The group is the place where the individual displays all the characteristics of his neurosis. The therapist takes advantage of this presentation of the individual's conflicts, and works with the individual in a group setting. The group, as such, does not exist.

A similar attitude has been adopted by Ginott (1961, 1968a), a psychoanalytically oriented group play therapist. He insists that the focus of treatment in group play therapy is always the individual child. No group goals are set and no group cohesion is aimed at. In conceding, however, that interpatient relations are an important element in group

treatment, Ginott seems to bridge the gap between individual oriented and group oriented group therapists.

The group oriented therapist. In contrast with the individual-oriented therapists, there are those who focus on the group as a unit. Such a therapist is less overtly active and is more of a catalyst of intra-group interaction. Hobbs (in Rogers, 1951, p.305) is a spokesman of this approach:

> The most challenging new element in the group situation is the possibility of releasing the therapeutic potential of the group itself. Group therapy, and not individual therapy in a group is the goal. If the therapist is skillful, the group itself becomes a therapeutic agent.

It is a source of confusion, perhaps, that the proponents of this approach to group therapy are frequently referred to as "client-centred counsellors"!

Functions of Group Counselling

Although there is an emphasis on individual problems being explored in the presence of other people, group counselling means much more than the mere provision of public therapy. This section will summarize some of the chief functions of what Hadley (1960, p.228) termed the "miniature and controlled social situation" of the group under the following headings:

(i) Support
(ii) Insight
(iii) Identification and modelling
(iv) Catharsis
(v) Desensitization
(vi) Operant conditioning

(i) Support. For most counsellees, the group offers an emotional support that comes from a feeling of belonging. To the child who feels

rejected or socially inadequate, in particular, the realization that others have similar feelings and that they can accept him in a "give and receive" relationship is in itself therapeutic. Or, as expressed by Foulkes and Anthony (1965, p.27):

> Being a respected and effective member of the group, being accepted, being able to share, to participate, belong to the basic constructive experiences of human life.

Furthermore, as Ginott (1961) pointed out, it is less threatening for a child to enter a new situation in the company of other children of his own age. The presence of other children in his group play therapy sessions was thought by Ginott to diminish tension, stimulate activity and participation, and provide opportunities for multilateral relationships unavailable in individual play therapy.

This supportive role of group therapy may be interpreted in reinforcement terms. Despite his psychoanalytic orientation, even Ginott (1968a, p.177) was prepared to couch this function in behaviouristic terms when he stated that "group therapy is based on the assumption that children will modify behaviour in exchange for acceptance...". Indeed, he even went so far as to suggest that the basic prerequisite for admission to therapy groups is a capacity for "social hunger ... a need to be accepted by peers and a desire to attain status and maintain esteem in a group". In other words, those children for whom social acceptance is not a potent reinforcer would be excluded from therapy groups.

It must be noted, however, that this supportive function of a group is a two-edged sword, for some counsellees never, in fact, proceed past this level of comfort, steadfastly resisting anything which makes them anxious about their neurotic status quo. Some, in fact, become

"group dependent". The therapeutic balance between comfort and discomfort is therefore a problem that taxes the judgement of the group therapist. I shall make further reference to this part later in my discussion of the applicability of cognitive dissonance theory to group counselling of children.

(ii) Insight. A second major function thought to be performed by a group lies in the general area of clarifying the counsellee's intellectual understanding of his behavioural dynamics and antecedents. The group operates in this respect by facilitating and sustaining communication processes and by exposing the individual member to new ideas and insight. In groups he has the opportunity to observe how other indivuals approach their problems and to benefit from the example and cumulative effect of other counsellees adopting more appropriate behaviour patterns. As Dreikurs and Sonstegard (1968, p.221) point out, "the child comes to see himself in others", a process which can only go on through listening to someone else discuss his difficulties.

According to Ginott (1968a), however, not all maladjusted children benefit equally from insight and for those that do (chiefly neurotics) the treatment of choice is not group, but individual therapy. For character-disordered children, for whom group therapy is indicated, Ginott considered that the specific therapeutic aim is to build their egos and correct their characters, a task which cannot be accomplished through the use of insight. Although these sentiments appear slightly iconoclastic coming from a psychoanalyst, they must be placed in the context of what appears to be Ginott's intention to devise appropriate

therapy for preadolescents, i.e. "those who are too old for play therapy, and too young for interview therapy". (Ginott, 1968b, p.273). He does not clarify his stand on this point, but it is possible that he sees insight oriented group therapy as being possible for adolescent and adult neurotics.

Despite its importance as a topic, this is not the appropriate place to examine the validity of the concept of therapeutic progress being achieved by insight. London's (1964) text does an admirable job of presenting the arguments raised by "action therapists" against the rationale of "insight therapy".

(iii) Identification and modelling. As well as providing an accepting parent surrogate, the group also offers children multilateral relationships unavailable in individual therapy. "An effeminate boy, for example, may derive ego strength from associating with an accepting masculine playmate" (Ginott, 1961, p.4). As an extension of this assumption that children will exert a remedial impact on each other, Ginott (1968a) has recommended that therapy groups be composed of children with dissimilar syndromes so that each child is exposed to identification figures different from and complementary to his own.

Recent research has explored the role of modelling in groups in reinforcement terms. Hinds and Roehlke (1970), for example, significantly increased adaptive behaviour and diminished interfering behaviours in pre-adolescent children by using systematic reinforcement in groups. They considered that as well as providing additional reinforcement, the presence of peers provided important modelling cues. Thus, by providing a model (or models) for desired behaviour, the child

is presented with behaviours he may imitate, thus greatly increasing the likelihood of receiving positive social reinforcement.

Another recent publication attempted to evaluate the particular contribution of such modelling on the acquisition of new behaviours. In a reasonably well-designed study, Warner and Hansen (1970) compared the effects of verbal reinforcement with and without the presence of models in groups. The subjects were junior high school students and the dependent variable was scores on a scale of alienation. The independent variable was the presence or absence of peers who scored below the mean on the alienation scale and were popular, stable, and of at least average scholastic ability. Both groups were given positive reinforcement for statements which suggested positive attitudes toward their position in the social structure. Although both reinforcement counselling groups resulted in improved alienation scores, relative to placebo and control groups, there were no significant differences between the effects of the model reinforcement and the verbal reinforcement counselling. It was suggested that the latter finding may have been a function of the length of time involved in counselling, the six week period possibly being too short a time for subjects to identify the models as either someone they desire to be like or as someone who receives rewards that the subjects would like to receive.

It would seem, then, that more research is necessary before one can validate the claim that modelling plays a significant role in group counselling. Some very fruitful hypotheses in this area have been advanced in a recent article by Mayer, et al (1969) who present an

interesting attempt to show the applicability of Festinger's (1957) cognitive dissonance theory and social learning theory to the group counselling of elementary school children. They point out that research findings from both approaches suggest that the probability of an attitudinal and/or behavioural change occurring is increased under certain conditions which can be manipulated by the therapist.

Festinger's cognitive dissonance theory centres around the idea that if a person is aware of various things that are not psychologically consistent with one another, he will, by a variety of means, try to make them more consistent. Faced with dissonance between items of information (e.g. "smoking causes lung cancer" - "I smoke" or "I like my new car" - "My new car gets poor mileage per gallon"), a person can change his opinion, change his behaviour, or distort his perceptions. Social learning theory is typified by Bandura and his associates' well known studies of **how** aggression levels increase as the result of the observation and imitation of aggressive models. (Bandura and Walters, 1963).

In translating these findings to the group therapy context, Mayer et al set up four main hypotheses:

1. The probability of an attitudinal and/or behavioural change occurring is enhanced when a counsellee sees a model or models do something that is contrary to or different than the counsellee's opinion or previous behaviour.

Counsellors, then, could well foster dissonance-producing situations by providing opportunities for their clients to observe contradictory items of information, e.g. Mary expects adults to make her decision but

observes that the counsellor trusts and expects her to make her own decisions. Mary is thus placed in a state of dissonance, an uncomfortable state of affairs which will probably make her question the validity of some of her reactions and feelings. She may, of course, reduce the dissonance by devaluing the source, i.e. by thinking that the counsellor simply does not care about her.

2. When a counsellee hears something from a model or models that is contrary to his opinions the chances of dissonance resulting in attitudinal and/or behavioural changes is increased. For example Jim may believe that it is morally bad to masturbate. But, during group discussion he hears other group members talking about this problem and also hears the counsellor and other group members accepting the behaviour.

3. The probability of an attitudinal or behavioural change occurring is enhanced when the counsellee says something that is contrary to his opinion or previous behaviour. Mayer et al discuss the example of a group of boys being suspected of urinating on sleeping bags. In group counselling sessions each boy expressed a negative attitude towards such behaviour, the unknown violator, of course, experiencing dissonance which could be achieved by the cessation of the behaviour under question. Happily, it worked! Role playing may be explained along these lines in that it provides opportunities for counsellees to say something contradictory to previous behaviour or attitudes.

4. Finally, counsellors can foster dissonance producing situations by providing opportunities for their clients to do something which is contradictory to their opinions or previous behaviour. For example, if

a counsellee who felt he could not participate in group activities is put into a position of joining in with a small group, then he could experience dissonance.

(iv) Catharsis. The cathartic impact of gaining relief through the release of emotions is probably no less true of group than of individual therapy. The ventilation of feelings can mean that the client no longer finds it necessary to protect himself against considering an emotionally disturbing area. It also means that each time such a topic is aired in an acceptant atmosphere of a group, he finds it easier to confront, so that gradually, by a process which behaviourists would equate with desensitization, it becomes less anxiety-provoking.

Group therapy is seen by Ginott (1961), as having an advantage over individual treatment in regard to catharsis. Besides "free associative" catharsis, it provides a social context which facilitates what he termed "vicarious" and "induced" catharsis. Thus, the more reticent child participates covertly as an involved spectator and the group can accelerate a child's awareness of the permissiveness of the setting.

Recent developments in research on the role of social learning upon aggression, however, would need to be taken into consideration when the group is seen as offering catharsis opportunities for the acting-out aggressive child. The danger that must be guarded against would be that such acting-out is reinforced by the therapist to the degree where other children begin to model themselves upon such an aggressive child.

(v) Desensitization. Several investigators have reported that group methods of systematic desensitization are effective in bringing about behaviour modifications, particularly in the area of test anxiety (Katahn et al, 1966; Kondas, 1967; Suinn, 1968; Cohen, 1969; Ihli and Garlington, 1969; Donner and Guerney, 1969). Other behavioural dimensions to have proven vulnerable to modification include phobic disorders (Lazarus, 1961) and general anxiety (Paul and Shannon, 1966).

There have been few studies comparing the relative efficacy of various forms of group counselling. One such study by Thoresen and Neuman (1968) is a possible forerunner of much needed research in this area. These writers compared systematic group desensitization (without formal discussion) with group insight counselling in reducing examination anxiety among 54 college undergraduates. The group desensitization treatment was found to reduce anxiety, as measured by three self-report measures of anxiety, significantly more than group insight treatment or two control group procedures, although differences were not found between these treatments on an observer checklist.

In the course of reporting the results of group methods of systematic desensitization, Lazarus (1961) commented on the rapidity with which patients who had had insight therapy recovered from phobias when given group desensitization. Such patients recovered after a mean of 10.1 group desensitization sessions, as compared with a mean of 20.4 sessions which were necessary for effective group desensitization when only this approach was employed. Lazarus interpreted this short-circuiting process in the following statement:

> The more usual clinical medium of verbal exchange ... may in itself bring about the incidental or non-specific reciprocal inhibition of neurotic responses. In other words, it is postulated that interview situations can sometimes evoke autonomic responses similar to those of deep muscle relaxation ... the therapeutic atmosphere of empathy and acceptance may in itself reciprocally inhibit neurotic anxieties.
> (Lazarus, 1961, p.509)

In other words, it is quite probable that traditional group therapy provides desensitization experience by allowing people to talk about anxiety-provoking topics or to participate in anxiety-provoking situations in a non-threatening supportive environment which is conducive to anti-anxiety responses. Such situations also create the cognitive dissonance which motivates modification of attitudes and/or behaviours.

(vi) Operant Conditioning. There has been relatively little research on the application of reinforcement procedures within groups. The results of recent investigations, however, suggests that with appropriate reinforcers for motivation, sequencing of learning, and specific objectives, children can be re-educated in behavioural patterns within groups. One such investigation by Warner and Hansen (1970) has already been discussed in this paper.

Hinds and Roehlke (1970) reported on the effects of systematic reinforcement over 20 group sessions with third, fourth and fifth grade children. Points were earned for specific adaptive behaviours selected for individual children, these points later being translated into permission to play a variety of cooperative games. The investigators reported that the procedures resulted in significant changes in adaptive and interfering behaviours and that behaviours in the counselling situation were transferred to subsequent classroom behaviours. An earlier study by Clement and Milne (1967) employed group play therapy and

tangible reinforcers to modify the behaviour of a small sample of 8 year old boys who were described as being "mildly maladjusted". Three groups were set up: a "token" group which received brass tokens exchangeable for food when social approach behaviour occurred, a verbal group which was verbally reinforced for approach behaviour, and a control group which met in a play room without a therapist and did what they wished. The results were that the token group exhibited an increase in social approach behaviour and a decrease in problem behaviour. The verbal group increased slightly on approach behaviour. The controls showed no improvements.

In the three studies outlined above, the group functioned as a social laboratory which provided a situation in which various social interactions could be performed. A study by Graubard (1969), however, adds another dimension to the utilization of reinforcement procedures within group contexts. Proceeding on the basis of evidence which strongly suggests that in certain sub-cultures the peer group can be a more powerful reinforcer than the teacher, Graubard attempted to enlist the peer culture of a delinquent group in the acquisition of academic skills and in the diminution of anti-school behaviour. A group of eight ten to twelve year old boys in residential treatment for anti-social behaviours comprised the subjects of the study. Graubard found that the procedure of making rewards for all subjects contingent on each subject's behaving appropriately was superior to giving rewards which were not contingent upon the subject's behaviour. Giving group reinforcers for appropriate classroom behaviour plus individual reinforcers for academic achievement proved to be the most efficacious. In such a delinquent group, the author felt that the group must

consciously legitimize learning so that individuals in the group do not have to concern themselves with loss of status for learning.

III. CONCLUDING STATEMENT

In the course of this paper I have pointed out several factors present in group counselling which support my earlier contention that this approach to the maladjusted person is a unique process. I have suggested that the group provides many experiences which cannot be duplicated in individual therapy. Thus, we recall that the group allows the therapist to observe the counsellee's social behaviour; it provides the counsellee with situations of cognitive dissonance rarely duplicated in individual therapy; the counsellee has a greater range of models with whom he can identify (or see himself reflected); the group itself can become the therapeutic medium; new behaviours can be learned and tried out in the protected environment; and so on. Increasingly, too, the group is being used as a context in which operant conditioning and desensitization procedures can be employed to modify behaviours.

What, then, of the future? No clearer or more pertinent statement than that of Anderson (1969, p.223) can be presented:

> Group counseling needs studies that specify concrete, measurable goals for individual clients, detailed analysis of verbal and non-verbal communication which constituted the treatment, and a variety of appropriate criteria. The formulation of general principles about group counseling still awaits the use of identical treatment procedures in different settings with different clientele, as well as multivariate approaches which compare several treatment procedures in similar settings with similar clientele.

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Note: A recent book that came to hand after this paper was written should provide a useful resume of group counselling with children: Gazda, G.M. (ed.) (1969). Theories and Methods of Group Counseling in the Schools. Springfield: C.C. Thomas.

PAPER 4: ARE ADJUSTMENT CLASSES FOR MALADJUSTED CHILDREN JUSTIFIED?

L.G. Rhodes,
District Psychologist,
Education Department.

Most papers in this symposium have tended to take a point of view in the face of the question that was posed and I would like to do the same.

I would like to present the negative or contrary case, i.e. "that classes for maladjusted children are not justified or justifiable."

One might be accused of being unrealistic in taking such a stand, but I hope to be able to show that at least we need to re-think the position of providing classes for maladjusted children. In order to do this I would like to present an educational argument or perhaps a special educational argument.

Everything that happens in school is bound to affect the child's emotional life and there is pretty clear evidence that emotional disturbance disrupts the child's learning (in the widest sense) and often that of other children in the class. It was Laycock who said, "The school has no choice of whether or not it will affect the mental health of its pupils. It has only the choice of how it will do so." This squarely places the responsibility in the hands of the school both in a preventive and rehabilitative way for dealing with maladjusted children. And, in fact, there is an increasing tendency for the treatment of maladjusted children to be taken over by educators. The question of how this is to be done still remains.

The Underwood Report para. 89 states

> "We can perhaps best approach the nature of maladjustment by saying that it is a term describing an individual's relation at a particular time to the people and circumstances which make up his environment. In our view, a child may be regarded as maladjusted who is developing in ways that have a bad effect on himself or his fellows and cannot, without help, be remedied by his parents, teachers and the other adults in ordinary contact with him."

This definition is fairly vague, or at least fairly general. The report does go on to elaborate the definition and does so largely in terms of a list of symptoms such that in my view almost any child could be considered to be maladjusted. It is this broadness and vagueness of what constitutes maladjustment which makes for great difficulty in the selection of children for adjustment classes and the treatment of children by way of special class provision, at least from the practical point of view.

For example, a class, even under ideal conditions, such as a well trained teacher and small numbers, cannot cater for a wide range of maladjustment, either in terms of type of behaviours shown by the children, or in terms of the age of the children showing the behaviour, or in the degree of maladjustment shown by the children selected and placed in such a class. To quote one type of maladjustment, and this very tentatively because I am not sure that socially deviant children are necessarily maladjusted or should be considered under this heading. However, be that as it may, children showing socially deviant or variant behaviour are seen most obviously and easily by teachers and are perhaps readily referred, but such children do not (speaking from experience) usually fit easily into a class for maladjusted children. In any case the socially maladjusted child probably tends to lose more than he

gains in an overall sense from segregation because he is removed from a context where socially acceptable behaviour is the norm, i.e. the ordinary class or school, and placed in a situation where unordinary behaviour is the norm. Then again, class placement alone is not sufficient if there is no communication between the Special class teacher and the home school and home class teacher. Furthermore, the environment to which the child returns may not change, although the child may, and he will return to an unchanged environment, which might even have been rejecting originally and may remain so when he returns. A similar limitation applies where family dynamics are involved in producing or contributing to the child's maladjustment. Special class placement opens the possibility of family counselling, but placement cannot be justified if ongoing family co-operation is not forthcoming. It is not always easy to establish that it will be when placement is considered. These shortcomings may be exacerbated when the child is placed in a school for maladjusted children, especially when this is not locally present.

Special class placement might be justifiable where school learning difficulties are part of the child's maladjustment, but even here a good educational argument could be made for the contrary view. To begin with there are some efficacy studies which suggest that special class placement produces few advantages. Efficacy studies on special day classes for mildly emotionally handicapped pupils suggest consistently that such pupils make as much or more progress in the regular class as they do in special education. For example, Rubin, Senison and Betwee (1966) found that disturbed children did as well in the

regular grades as in special classes, concluding that there is little or no evidence that special class programming is generally beneficial to emotionally disturbed children as a specific method of intervention and correction. Birch (1966), in his critical review of this experiment, comments "At the conclusion of the study the vast majority of the differences (in measures obtained) were not significant at the five percent level of confidence". This research is interesting because some comments made indicate that traditional medical labelling procedures were found to have limited utility in the programme. On the New Zealand scene, Read carried out a survey in 1967 on the efficacy of placement in an adjustment class in the Hutt Valley by way of a questionnaire. The results are stated in rather unqualified general terms, but they suggest that some improved school achievement resulted. Only 50% of headteachers, however, felt that the child was adequately adjusted after a period back in the ordinary school, and little over half the parents reported improved behaviour while their child was in the class. My own impression in the case of limited follow-up by means of interview and test results of a few children ex Mt. Wellington residential school, is that after a period of return, there is little or no change in the level or type of maladjustment displayed.

Evidence from efficacy studies would suggest, then, that we need to find better ways of serving children with maladjustment and associated learning disorders than by placing them in self-contained special classes (or schools). Classes for emotionally disturbed children should not be set up except as part of a research-based programme with testable hypotheses.

Another line of argument supporting the contention that classes for maladjusted children are not justifiable might be a consideration of labelling processes - of who labels children and how they are labelled and with what effects. Our past and present diagnostic procedures come under this heading. These procedures have probably been doing more harm than good in that they have resulted in disability labels and in that they have grouped children "homogeneously" in classes on the basis of these labels. Generally, diagnostic practices have been provided by a multidisciplinary team, usually consisting of pediatricians, social workers, psychologists, speech and hearing specialists, and sometimes educators. The avowed goal of this approach has been to look at the complete child, but the outcome more often has been merely to label him - emotionally disturbed, minimally cerebrally dysfunctioning, etc., depending on the predispositions, idiosyncracies and backgrounds of the team members. Too, the team usually has looked for causation, and diagnosis tends to stop when something has been found wrong with the child, when the why has either been found or conjectured, and when some justification has been found for recommending placement in a special educational class.

Alternatively, and more commonly, the assessment of educational potential has been left to the school psychologist, who generally administers - in an hour or so - a psychometric battery consisting of individual tests of intelligence, achievement, social and personal adjustment. Again the purpose often is, or the result is, to label the child so as to make him eligible for special educational services.

The label applied to the child serves as a sanction for

administrative action, meaning placement into a special class or other special programme. The whole procedure tells us little about a child that the teacher did not know in a vague way already and teachers have no information about what to do for the child after placement changes are made. Moving a child from one classroom to another is an administrative action, it is not an act of understanding or explanation.

A group of children labelled as emotionally disturbed in a classroom with a teacher trained to work with such a group is not in itself "special" education. Placing a small number of children into a class does not necessarily constitute anything special. It is what the teacher does, and does with administrative and supervisory assistance and direction, that determines whether there is anything special about the special education programme.

Labelling tends to fasten the attention on the handicap rather than on the child. Failure to understand and provide individualized programming is probably a major reason for many of the problems faced by teachers in the field of special education. Teachers are trained to think in terms of the emotionally disturbed child rather than in terms of a child who may be retarded because of some emotional problems. The handicapped child is more like the ordinary child than he is different from him.

Another point is that handicaps do not usually come singly. One of the lessons one learns in studying handicapped children is that when children are selected on the basis of a single label or criteria the result is not really homogeneity at all but only selection in terms of a major difficulty. Other difficulties do not disappear as the result

of dealing with only one handicap.

The proliferation of a number of discrete categories of educational handicap does not match the reality of childhood difficulties and does not provide a real basis for developing individualized instruction. That is, if we are saying that each child is different and has unique learning patterns and instructional needs, then why make a pretence about a rationale for grouping children - as emotionally disturbed or maladjusted?

Fisher (1967) sums up the problem

> "We seem to be possessed with categories and organizational designs which entrench the categories. Are we so sure that special classes broken down into categories - slow learners, neurologically impaired, etc. are doing the job. While the process may be administratively convenient, there is no doubt that the procedure has made special education special, isolated it and in so doing perpetualised the isolationism and attending mysticism which has stood in the way of special education development." (p.10.)

Reger, Schroeder and Uschold (1968) quote a result of labelling and special educational placement.

> "Special educational programming faces a critical danger today in becoming the vehicle for preventing change in the general curriculum. It is becoming increasingly easier as programmes multiply and our alertness to problems sharpens, to remove children who do not fit the general curriculum rather than to think in terms of making changes in the general curriculum to accommodate the child. If a school believes that its curriculum programme is adequate it will never be proven wrong as long as any child who is unable to fit the pattern is removed and placed in a special educational programme. If a child and his curriculum are not aligned with each other, we can label the child and remove him." (p.13)

What is the evidence against the continued use of these diagnostic practices and disability labels?

First, we must examine the effects of these disability labels on

the attitudes and expectancies of teachers. These we can extrapolate from studies by Rosenthal and Jacobson (1966) who set out to determine whether or not the expectancies of teachers influenced pupil progress. Working with elementary school teachers across the first six grades, they obtained pretest measures on pupils by using intelligence and achievement tests. A sample of pupils was randomly drawn and labelled "rapid learners" with hidden potential. Teachers were told that these children would show unusual intellectual gains and school progress during the year. All pupils were retested late in the school year. Not all differences were statistically significant, but the gains of the children who had been arbitrarily labelled rapid learners were significantly greater than those of the other pupils, with especially dramatic changes in the first and second grades. To extrapolate from this study, we must expect that labelling a child "handicapped" reduces the teacher's expectancy for him to succeed.

Secondly, we must examine the effects of these disability labels on the pupils themselves. Certainly some of these labels are not badges of distinction. Separating a child from other children in his neighbourhood - or removing him from the regular classroom for therapy or special class placement - probably has a serious debilitating effect on his self-image. Here again research is limited, but supportive of this contention, Goffman (1961) has described the stripping and mortification process that takes place when an individual is placed in a residential facility. Meyerowitz (1965) demonstrated that a group of educable mentally retarded pupils increased in feelings of self degradation after one year in special classes. More recent results

indicate that special class placement, instead of helping such a pupil to adjust to his neighbourhood peers, actually hinders him (Meyerowitz 1967). While much more research is needed, we cannot ignore the evidence that removing a handicapped child from regular classes for special education probably contributes substantially to his feelings of inferiority and problems of acceptance. This would probably apply to an even greater extent in the case of emotionally disturbed pupils.

Another reason self-contained special classes are less justifiable today than in the past is that regular school programmes are coming to be better able to deal with individual differences in pupils. No longer is the choice merely between a self-contained special class or a self-contained regular elementary classroom. Educational software and hardware is advancing to a point where alternatives are possible. (Dunn, 1968). Four such advances could be mentioned:

Changes in school organization:

In place of self-contained regular classrooms in which there is a static teacher-class unit, there is increasingly more team-teaching, ungraded classes, and flexible groupings.

Curricular changes:

Instead of one method of teaching reading, many new methods are now available. There is increased attention to learning styles. Contemporary mathematics programmes teach concepts at all levels. More programmed textbooks are being used.

Changes in professional State school personnel:

More advisory and specialist teachers are now available - psychologists, guidance counsellors, remedial teachers, subject advisers, teacher

aids. Some teachers are acting as teacher-co-ordinators, curriculum development is a team effort and regular teachers are better able to cope with individual differences, but much still needs to be done.

Hardware Changes:

Teaching machines, feedback typewriters, Educational T.V. video tapes and so on are being used for self instruction more and more.

Dunn states

> "There is an important difference between regular educators talking us into trying to remediate or live with the learning difficulties of pupils with which they have not been able to deal; versus striving to evolve a special educational programme that is either developmental in nature, wherein we assume responsibility for the total education of more severely handicapped children from an early age, or is supportive in nature, wherein general education would continue to have central responsibility for the vast majority of children with mild learning difficulties - with people serving as resource teachers in devising effective prescriptions and in tutoring such pupils."

We need to do away with many existing disability labels and the present practice of grouping children by means of these labels into endless discrete special classes. Instead, we should try to keep slow learning or maladjusted children more in the main stream of education with special educators serving as diagnostic, clinical, remedial, resource room, itinerant and/or team teachers, consultants and developers of instructional materials and prescriptions for effective teaching.

Instead of disability labels we need to substitute labels which describe the kind of educational intervention which is required. This would shorten the list and we could thus talk of children who need social training, conative-affective or personality development, etc. At the heart of such a plan are master teachers, capable of implementing precisely defined educational programmes.

I have tried to take a point of view that special classes for mildly emotionally disturbed children are barely justified at the present time and may be less justifiable in the future, at least in the form that they now take. This may be stated as saying that the purpose of special education should be to make the need for it obsolete.

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PAPER 5 THE INSTITUTIONAL CARE OF SOCIALLY MALADJUSTED CHILDREN

B.C. Atwool,
Warden,
University of Waikato

I intend to deal with this topic under the four broad headings of when, who, how and what, with a few concluding words on after-care. Firstly, when should institutional care be used for a socially maladjusted child in preference to other methods of care, or to put it another way, what are the relative merits of institutional care in relation to other methods? Generally speaking, institutions should not be used too readily as a means of treating maladjusted children, because they inevitably involve some element of artificiality in the environment and a loss of intimate personal relationships within a family group, with consequent problems of transition and reorientation. At the same time, I do not agree with the school of thought which holds the view that the worst home is better than the best institution. To quote from Garrison, Kingston and Bernard, "When children's needs have been consistently denied for a prolonged period it is often necessary to bring about a marked change in environment to effect improved behaviour." The answer must depend on the circumstances of each individual case, and on a professional judgement in the light of those circumstances, and I believe that institutions can play a positive role in this field.

Next, what sort of maladjusted children need institutional care? Again it is very hard to generalise. Sometimes the degree, depth or persistence in time of the maladjustment will be the governing factor, but there are some children, very seriously maladjusted, whose problems

appear to be further aggravated by institutional living. Some are threatened by peer group pressures and fall into the role of whipping boy, while others are susceptible to these pressures in terms of making a bid for the wrong kind of status by behaviour responses which are in opposition to those which the institution is trying to inculcate. A further complicating factor is that the positive role of the institution is sometimes overshadowed by its "dustbin" role, i.e. the element of expediency when a child must be removed from his home and no suitable foster home is available, or there is community pressure for institutional placement because of the child's antisocial behaviour. Again, the range of institutional facilities in New Zealand is limited, resulting in children with a wide variety of problems and needs being lumped together. In particular, very little is available in the way of therapeutic communities for severely disturbed adolescents where there is a very high staffing ratio, where all staff are well trained, and where there can be an element of selection if a child does not fit into the group. In these respects the situation here in New Zealand can be said to compare unfavourably with that in America.

In practical terms, it is probably true to say that a child should qualify for institutional care under one of two general criteria:

(1) When his level of maladjustment is severe and persistent enough to make it unlikely that he could exist anywhere else in the community, within the limits of available resources, without causing harm to himself and/or others. Such a criterion usually involves a progressive series of failures in various social

situations, and leaves the institution in the position of a "last ditch stand". It also causes the wistful catch-cry among institutional workers "If only we had got him earlier," but at that stage institutional care might not have been justified in the absence of an accurate crystal ball.

(2) When there are sufficient positive features in the home situation to suggest that the child's behaviour and patterns of interaction could be improved by a period of institutional care, during which family ties can be maintained and used in a supporting role in treatment. Ideally, counselling of parents should be an integral part of such treatment.

The next major issue is, can behaviour be modified through institutional care? I believe so, but not by the traditional methods of this form of training, i.e. regimentation and discipline in the sense of enforcing conformity. A great many people seem to feel that strict discipline of this nature would be the answer to many current social problems. The primary basis of my philosophy of institutional care is that extra doses of this "normal" discipline do not provide the answer. Child development is generally regarded as a series of progressive steps or stages, each one of which has to be worked through satisfactorily if further development is not to be impaired. Maladjusted children who qualify for institutional care are almost always psychologically damaged, and in most cases are hostile towards all forms of authority, real or imagined, whether this hostility is revealed in aggressive behaviour or hidden under a veneer of polite subservience. It is all too easy, then, by the

use of traditional types of discipline, to reinforce rather than change the roots of maladjustment, and to drive the problems deeper. Regimentation and strict discipline can often produce conformity, and to equate conformity with progress is in my opinion a trap which must be avoided. The acid test of institutional treatment is not how the child behaves while in residence, but whether he can afterwards make and maintain a satisfactory level of adjustment to life in the world outside. It is a great temptation to base the structure and organization of an institution more on smooth running than on service, but to quote an analogy by Professor W.G. Minn,

> "Those in administrative positions need to remind themselves that the functioning of the machine, though it may be a beautiful thing in itself, is of value to the community only if it results in better service to the citizens for whom it works."

What, then, <u>do</u> we do to help such children towards a better level of social adjustment. I believe that an institutional treatment programme should operate on three integrated levels, as follows:

(1) The individual level which is the cornerstone, and of which the primary aspect is the development of personal relationships of sufficient strength to provide in time the inner-directed motivation to change, and then to maintain socially-acceptable standards. Usually one member of staff is responsible for counselling with a child, but the same child will have to relate individually to many other staff members, each of whom will act as a living advertisement of the standards and values which represent the goals of the treatment programme. Furthermore, each person will to some extent represent authority which is the focus of much hostility, conscious or unconscious, and

as such will be subjected to supercritical analysis by children who are actively looking for faults or inconsistencies which may bolster up their distorted concept of society and adult authority. Paradoxically, the same children will not respect the staff member who, in an effort to improve his personal relationships with them, abdicates from his role and condones behaviour which they know to be wrong. I believe that authority can be handled in a positive fashion whereby a child's behaviour can be criticised without him feeling rejected as a person, whereby he can if necessary be punished but at the same time still feel accepted and be motivated to greater efforts in the future. Returning to the counselling or casework function, I consider that acceptance of responsibility for behaviour is a key factor, even more so than the search for causes in background history. This is the core of reality therapy as developed by Glasser, who defines responsibility as "the ability to fulfil one's needs, and to do so in a way that does not deprive others of the ability to fulfil their needs". His reality therapy concept is made up of three separate but intimately interwoven procedures. First there is involvement with the patient to the degree that he can begin to face reality and see how his behaviour is unrealistic. Secondly, the therapist must reject the behaviour which is unrealistic, but still accept the patient and maintain his involvement with him. Lastly, the therapist must teach the patient better ways to fulfil his needs within the confines of reality. As applied to this field, the counsellor must be able to empathise with the child at his level in his world, but at

the same time help him towards a realistic appraisal of his family situation, his own needs and his goals for the future, with the development of sufficient motivation and self-confidence to work towards them. In this connection, the institution can provide opportunities for environmental manipulation to produce success experiences which are often a real novelty for a child with a persistent history of failure in almost every social situation.

(2) The group level, which has three aspects. Firstly, the institution should if possible be divided into group living units if, as is usually the case, it contains more than twenty to thirty children. The smaller the group, the less need for regimentation and the greater the use which can be made of the second aspect, which is group work techniques. This includes therapeutic groups and structured groups with a specific orientation, such as new admission and pre-discharge groups, and ad hoc groups which are continually forming spontaneously in the course of daily living. The trained and experienced staff member learns that involvement with children on this level becomes a far more effective method of supervision than the "boundary-riding" or "head-counting" approach, and he can stimulate discussion and constructive activity which will continue and develop after he has moved on. The third aspect of the group level lies in the specialised fields of education, vocational training and recreation. Again the emphasis should be on stimulation, flexibility and sufficient variety of facilities to appeal in some way to all individuals.

(3) The Community level, with the two aspects of the institutional community and the wider community of which it should be an integral part. As regards the former, a lot can be done to encourage participation by the children in its organisation, and to use it for practical demonstrations of some of the principles on which individual and group counselling are based. One of the biggest advantages of institutional treatment is the fact that the children are available 24 hours a day, and that some control can be exercised over their environment. I believe, however, that it is very difficult to prepare children for readjustment to life in society unless they have the opportunity to keep in touch with the world outside the institution. To this end, a great deal can be done by Sports and Youth Clubs, Churches, Service Clubs and other organisations to give them opportunities for participation, and by the ordinary man in the street in terms of acceptance without stigma. I also consider that the children can build up their own sense of personal worth, often sadly lacking, by doing things for other people as well as having things done for them, i.e. by learning to "pay the rent" for their place in society.

The methods thus described represent my opinion of the aims of institutional care of maladjusted children, but their effectiveness is sometimes hampered by practical limitations. A major factor under this heading is the calibre, training and turnover of the staff. Policies which involve practising what you preach, being open to expressed criticism, having to back decisions with reasoned argument,

allowing opportunities for self-expression, showing respect for an individual who is obviously "having you on" - such policies make very real demands on staff members who frequently have little or no social work background and who receive only minimal on-the-job training. Even those with professional training, like teachers, find that they must make major adjustments in their approach and methods in an institutional setting. Furthermore, staff shortages and the unavoidable need for physical care and supervision of the children 24 hours a day, often combine to put pressure on the newcomer to become fully operational as quickly as possible, from the point of view of quantity rather than quality of work. Training under these circumstances often consists of lip service to psychological considerations, and major emphasis on the "handling" rather than understanding or working through of problems and situations. There is, then, a tendency for the new worker's perspective to become distorted so that he equates conformity with progress, and looks on the smooth running of the institution as the primary objective - the very trap we are trying to avoid. Such an attitude can be quite infectious and can have a marked effect on staff morale, which can in turn lead to an increase of disciplinary problems, and/or to an increase in conformity for personal gain or reward without any real thought or progress.

Another problem which can produce a lot of tension among staff and children is that of absconding. Without full security, which involves shutting children right away from the community, such behaviour will always occur occasionally, and an increase in direct

supervision can often create a challenge type of situation which results in further abscondings. Ideally, one should not pay too much attention to the absconder, who is running away from his own problems more than the institution, but in practical terms he often commits offences to eat, clothe himself and move about the country, and he can make things difficult for the other children in terms of an adverse effect on public relations and their acceptance in the community.

So institutional care of maladjusted children in New Zealand today involves some compromises, but there are positive signs of progress such as increased staff/child involvement, a greater range of constructive recreational facilities, a considerable increase in the numbers of teaching staff, and latterly the establishment by the Child Welfare Divison of a residential staff training school for institution workers. I look forward to the day when there are more specialists available, plus enough staff in each institution with sufficient grounding in the basic principles of social work and special education to create an atmosphere in which excessive conformity by a child can cause as much concern as antisocial behaviour, and in which real progress is the primary goal. Then, I consider that the child should gain from this environment a real sense of security and a feeling that there is a place for him in "normal" society, and people who believe in his ability to overcome his problems who can accept him while he goes through the difficult process of doing so.

Finally, I want to make the point that institutional care of socially maladjusted children never achieves its aims in terms of an end product, because at best it can only be a step along the road to

readjustment, the end of which must be a position of relative independence within normal society. In this connection, follow-up or after-care work is of vital importance. Ideally, the child should have the opportunity of some contact with the after-care worker prior to discharge, and the worker should be aware of the content of preparatory work by the institution and the child's response, so that there can be some element of continuity. I believe that there is considerable room for improvement within this field in New Zealand, and that after-care work should be regarded as a part of the whole process of institutional care rather than merely evidence of its success or failure.

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PAPER 6 THE DIAGNOSIS AND MANAGEMENT OF THE AUTISTIC CHILD

Dr. S. Blackburn.
A Hamilton Child Psychiatrist.

Definition: Autism: Morbid self-admiration, absorption in fantasy.
(Concise Oxford Dictionary)

Historical: Infantile Autism was first described by Kanner in 1943, although the symptoms, as opposed to the syndrome, had been described previously. Kanner's description aroused great interest because psychotic disorders of childhood had not been sub-classified previously, but all lumped together under the label "childhood psychosis" or "childhood schizophrenia". A heated debate followed and still continues over the differentiation of autism from childhood schizophrenia. When Kanner first delineated the syndrome of early infantile autism he emphasized that, in contrast to other psychoses of childhood, abnormalities were present from early infancy. However, he later found a similar clinical picture in children who had appeared normal from birth and then regressed at the age of 18 months to 2 years. The age of onset is important as it is one factor which differentiates it from childhood schizophrenia. The other features which differentiate autism from childhood schizophrenia are:

1. A low rate of schizophrenia in relatives of autistic children and a high incidence in relatives of childhood schizophrenics.
2. High socio-economic status of parents of autistic children as opposed to average distribution of parents of schizophrenics.
3. Differences in patterns of cognitive functions.
4. Differences in the course of the illness; hallucinations and delusions may develop in schizophrenic children but are very rare in autistic children.

The psychoses which develop in the middle years of childhood, that is from about 3 to 8 years of age, are usually of organic origin, or rather of provable organic origin, such as lipoidoses and other degenerative conditions. Early onset schizophrenia is rare before the age of 8 or 9.

Diagnosis

Diagnosis is difficult because the condition is rare and no doctor or teacher sees many. Also there is often pressure upon the doctor to make a diagnosis of autism rather than intellectual handicap, perhaps because it is more socially acceptable, and also because some workers believe that autism is treatable and even reversible, although this belief is not supported by follow-up studies. Mildred Creak in the report of the British Working Party on childhood psychosis, 1961, put forward 9 diagnostic points. However, different people have interpreted the 9 points differently and not all are present in every case. Other workers have divided them into "nuclear" cases showing all, and "atypical" cases showing some of the 9 criteria of diagnosis. Creak did not specify the age of onset in the 9 points, but of her 102 cases, 79 did not show regression, and 23 did, 13 of those 23 regressing before the age of 3. The two major criteria of diagnosis are extreme aloneness and resistance to change. The extreme aloneness is shown by aloofness, lack of interest in people, avoidance of eye-to-eye contact and a failure to form normal relationships with people. Autistic children appear to regard people and inanimate objects in the same way. They do not show warmth or affection and have no sense of humour. The resistance to change is shown in screaming attacks if the furniture is changed around or a routine is altered and even

refusal to change clothing. The other diagnostic features are:

Speech disorders. All autistic children show abnormalities of speech and in Rutter's series over half had no speech by the age of 5 years. They all show a relative lack of response to sounds, including an absence of the startle response in infancy, and deafness is often suspected. Paradoxically, certain noises cause acute distress, and one often sees autistic children putting their hands over their ears to shut out quite ordinary noises. Echolalia is common, as is confusion of you/I. Autistic children rarely use "I" or "you" but refer to themselves as "him" or by name. "Yes" and "no" are also rarely used and questions are answered by repeating the question.

Ritualistic and compulsive phenomena. Abnormal preoccupation with objects is common, such as twirling pieces of string or a plug on a chain or a piece of ribbon, together with acute distress if the object is lost. Some children insist on fixed routines such as folding their clothes only in a particular order or eating different foods in a particular order. Some children will eat only a certain food for a time such as chips or Marmite sandwiches or even candy-floss, or else will eat or drink only from a particular kind of plate or cup.

Abnormalities of posture, such as tiptoeing or whirling are common. Some children show an amazing degree of control and lack of fear, so that they can run along narrow window-ledges or the back of a sofa. Stereotyped, repetitive movements of hands are especially common.

Abnormal fears occur, when the child will scream and tremble at ordinary sights or sounds, such as people or animals or certain noises.

Sensory abnormalities include the relative lack of response to pain as

well as to sound. They seem to be unaware of many visual and auditory stimuli.

Self-destructive tendencies occur in about one-third of autistic children, usually wrist-biting or head-banging.

"Islets of intelligence" is the description of the uneven functioning seen in testing autistic children. The Maudsley series showed:

40% were untestable or had I.Q. less than 50
30% scored 50 to 69
30% scored 70 or more

Rutter's series showed extreme variability in functioning, to a greater extent than control children of the same I.Q. He found they were often untestable on verbal tasks, and if testable were at their worst on those demanding abstract thought, symbolism or sequential logic. They were best on tasks requiring manipulative or visuo-spatial skills, or verbal tasks requiring only immediate memory. This sort of pattern was much more marked in those autistic children with no speech than in those who had developed speech so that the so-called "islets of intelligence" pattern may well be associated with defects in the use and understanding of language.

Causes of autism.

Originally Kanner put forward a theory of abnormal mothering, a lack of a normal relationship between mother and infant from birth. He reported the mothers as being cold, obsessional intellectuals. The excess of highly intelligent parents reported by Kanner was suspected by many workers to be an artefact of referral, but many later studies have confirmed it, even those studies which have not confirmed Kanner's other findings. In particular, Lotter screened the entire population

of 8 to 10 year olds in the County of Middlesex to obtain an unselected sample of autistic children and found a marked excess of parents of high educational and occupational status. Creak also confirmed Kanner's findings of an excess of highly intelligent parents but failed to confirm his theory of "refrigerator mothers". Pitfield and Oppenheim studied mothers of the autistic children seen by Creak and they found that, compared with mothers of normal children and Mongol children, they were more lax, indulgent and uncertain of their attitudes, that is <u>not</u> detached and rigid as Kanner suggested. They pointed out that this is the sort of picture one would expect if the child's abnormal behaviour had shaped parental attitudes rather than the other way round. Incidentally, mothers of brain-damaged children showed more abnormalities on personality testing than mothers of autistic children.

Many workers have suspected an organic cause. Neurological examination usually reveals no abnormality apart from disorders of tone or coordination. Many key symptoms such as autism, stereotypes, speech abnormalities and obsessive behaviour, when they occur in isolation, are associated with brain injury, but the complete syndrome is not usually found with overt brain disease. However, certain organic disorders <u>can</u> mimic autism in every respect, for instance neurosyphilis, toxoplasmosis and it is common in children with retrolental fibroplasia, a condition associated with over-oxygeneration of premature infants which causes blindness. In Creak's series, a small number confidently diagnosed as autistic went on to develop frank neurological disease such as brain tumour or degenerative conditions. In both Creak's and Rutter's cases, some children developed fits long

after the onset of the autism (7 out of 100 in Creak's cases, 10 out of 63 in Rutter's). There are no post-mortem studies of children who have been psychotic from infancy but there are several reports of abnormal brain pathology in children developing psychosis at 3 or 4 years. One post-mortem report showed extensive damage to the primary auditory projection pathways which would add support to the theory that the abnormalities of language in autism are due to disorders or defects of receptor functions.

A significant proportion of autistic children are below the expected height and weight and their skeletal maturity is retarded, but metabolic studies are inconclusive.

E.E.G. studies are also inconclusive as findings are often contradictory probably because of the differing criteria for E.E.G. abnormalities. Some workers have reported over 50% of records of autistic children as being abnormal while others have quoted any percentage from 10% up to 50%. However, there is no doubt that some autistic children show frank epilepsy both of the major and minor types.

Twin studies are also inconclusive as so few twins have been reported and those which have are not proven mono- or di-zygotic. Chromosome abnormalities have been looked for in one series of 10 cases but none were found.

In summary, the main factors invoked have been:

1. Genetic
2. "Brain damage"
3. Psychogenic
4. Abnormalities in the reinforcement of the child's behaviour
5. Cognitive defects
6. Perceptual abnormalities.

Most theories involve a combination of some of these factors. Few believe that the condition is entirely psychogenic now, and most of the original adherents of the view have modified their original theories and postulate an interaction between an abnormal environment and a vulnerable child. The behaviourist view or "differential reinforcement" theory is speculative in my opinion and there is no good evidence for abnormalities in parental patterns of reinforcement. Some workers have held that autism is just another form of intellectual subnormality, but the fact that some children of normal intelligence show exactly the same symptoms makes this unlikely. There are close parallels between autistic children and children with receptive aphasia which could be interpreted as supportive evidence for the view that failure in comprehension of speech is the basic factor, all other abnormalities stemming from it. The abnormal responses to auditory and visual stimuli suggest an abnormality of perception and integration of stimuli. Rimland went even further and postulated that autism is "an inability to relate new stimuli to remembered experience".

Prognosis.

Rutter and Lockyer have recently published a 5 to 15 year follow-up study of 63 children who attended the Maudsley Hospital with autism from 1950 to 1958. They found that contrary to expectation the original I.Q. is well correlated with the final outcome, and is of course closely related to the presence or absence of speech. The outcome appears to be unrelated to the type of treatment received apart from the fact that children cared for in long-stay institutions tended to have a Vineland S.Q. at follow-up much lower than the initial I.Q.

Creak found no evidence in her cases that psychiatric treatment had influenced the outcome.

TREATMENT:

Psychotherapy. As noted by Creak there is little evidence that psychotherapy is of use. However, Escalona (Menninger Clinic, 1948) classified psychotherapy into "expressive" and "suppressive". "Expressive" psychotherapy consisted of encouraging expression of previously unconscious material, interpretation of fantasies, exploration of the relationship between emotions and their sources. There was no improvement in autistic children treated this way. Suppressive therapy consisted of discouraging the expression and acting out of fantasies and providing as much gratification as possible in realistic pursuits. Those children treated with "suppressive" therapy were said to improve in their behaviour, although the underlying psychosis was said to be unchanged. This sounds like behaviour therapy to me. Some workers have concentrated on psychotherapy with the parents and although there is no convincing evidence that parental attitudes are the cause of the condition, nevertheless some sort of supportive therapy may be of help in relieving their distress, guilt and ambivalence induced by the child's illness.

Behaviour therapy, as pioneered by Ferster, has been successful in altering the abnormal behaviour of the autistic child. Both positive and negative reinforcement have been used to eliminate undesirable behaviour and to develop desired new forms of behaviour. One can imagine there is some difficulty in finding positive reinforcers for autistic children, but they do seem to respond to sweets and attention

and even to praise. Electric shocks have been used as negative reinforcers and occasionally isolation or withdrawal of attention, both of which have obvious drawbacks for autistic children. Lovaas has shown what many workers have suspected, that sympathy and attention given at times of self-inflicted injury tend to increase the frequency of self-destructive behaviour. This is of obvious importance in counselling parents who often find it very difficult to punish their autistic child for something which "he can't help". There have also been some attempts to induce speech using behaviour therapy. Salzinger took two autistic children, the first one being seen daily for 20 months from the age of 3 years 10 months, and speaking almost entirely in sentences at the end of this time. However, the second child, who was 3 years at the start of treatment had only 25 words after 61 sessions of which only 4 or 5 were used frequently and were easily understandable. Lovaas and others have pointed out the major drawback of behaviour therapy: results are often short-lived and are situation-specific; that is, no generalisation occurs. However, there have been some striking successes in the use of behaviour therapy, in particular in removing severely handicapping behaviour, which benefits not only the child but also the parents.

Drugs have been used to damp down aggressive behaviour but no specific treatment for the underlying condition has been evolved.

Other techniques of treatment. Various workers have suggested that use should be made of sensory modalities other than sight and hearing since autistic children are resistant to auditory and visual stimuli. Touch seems to be important. One mother reported that her autistic

son could not learn by watching her do something or by being told how to do it but when, in desperation, she took his hands in hers and went through the movements, he learned quite quickly. Rudolf Steiner schools, in England, use music and drama in the treatment of autistic children, and they are encouraged to sing their attempts at communication or to tell their stories through glove puppets. Rudolf Steiner schools have a good success-rate with autistic children, in that some manage to take their place in the community and become self-supporting in spite of oddities of expression and difficulties in forming normal relationships with other people. However one must bear in mind that they are highly selective in their intake and tend to take those children who would do well anyway, that is, those who develop speech and have a relatively high I.Q.

Little has been done in the field of applying the techniques of teaching the blind and the deaf to autistic children, which one would expect to be of some use.

"The talking typewriter" awaits proper assessment. Unfortunately news of it leaked to the popular press before it had been tried and tested and has been followed by demands by parents to have some sort of magic treatment for their children.

It seems obvious to me that much more work on the fundamental pathology is necessary to find a rational method of treatment including education, but it seems reasonable at the moment to try any techniques which will bring the autistic child out of his isolation, encourage him to take part in reality-testing situations and make full use of whatever intellectual and sensory functions are unimpaired.

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